2015-2016 Amistad High School Athletic Participation Packet

If you have any questions, please contact athletic director, Mr. Jay Fellows at 203-499-9474 or jayfellows@achievementfirst.org

Deadlines for submission: Fall Sports - 08/26/2015 / Cheerleading - 11/09/2015 / Girls Basketball - 11/27/2015
Boys Basketball - 12/04/2015 / Spring Sports - 03/18/2016

STUDENT INFORMATION

First name

Last name

Parent/Guardian name

Parent phone number

Address

Emergency contact 1st choice

Emergency contact phone 1st choice

Emergency contact 2nd choice

Emergency contact phone 2nd choice

PARTICIPATION AND PARENT APPROVAL

This section must be completed by the student and his/her parent or guardian and approved by the athletic department before a student is allowed to participate or tryout or compete in interscholastic athletics sponsored by Amistad High School.

I give my consent for the above named student to participate in the following interscholastic sport(s) this 2014-2015 school year and understand that by signing this form I will be subject to athletic department policies as put forth in the athletic department handbook. You may sign up for multiple sports in all three seasons.

Fall Sports

- ☐ Girls' Volleyball
- ☐ Boys' Cross Country
- ☐ Girls' Cross Country
- ☐ Boys' Soccer
- ☐ Girls' Soccer
- ☐ Football

Winter Sports

- ☐ Boys' Basketball
- ☐ Girls' Basketball
- ☐ Cheerleading

Spring Sports

- ☐ Boys' Lacrosse
- ☐ Girls' Lacrosse
- ☐ Boys' Track
- ☐ Girls' Track

Parent's/Guardian's signature

Date

ACKNOWLEDGEMENT OF WARNING & RELEASE OF LIABILITY BY PARENT/GUARDIAN IF STUDENT IS A MINOR

I, _____ (**parent/guardian**), hereby acknowledge that I have been properly advised, cautioned and warned by the personnel of Amistad High School of the risks involved with _____'s (**student**) participation in the following sport(s): _____ (**choose from soccer, football, cross country, volleyball, field hockey, basketball, track, cheerleading, and/or lacrosse**). I acknowledge that even with the best coaching, use of appropriate equipment and strict observance of rules, injuries are still a possibility and that _____ (**student**) is exposing himself/herself to the risk of serious injury, including but not limited to, the risk of sprains, fractures and ligament and/or cartilage damage which could result in a temporary or permanent, partial or complete, impairment in the use of his/her limbs; brain damage; paralysis; or even death. Having been so cautioned and warned, I still permit him/her to participate in the above sport(s), and further acknowledge that I do so with full knowledge and understanding of the risk or serious injury to which he/she is exposing himself/herself to by such participation. I hereby hold Amistad Academy, Inc., Achievement First, Inc. and any of their affiliates, employees or agents harmless from and against any liability resulting from or occurring in connection with _____'s (**student**) participation in the above sport(s) including but not limited to injury, death or sickness occurring in connection with or aggregated by his/her participation in the sport listed above and any consequences directly or indirectly resulting from such participation.

Parent's/Guardian's signature | Date

ACKNOWLEDGEMENT OF WARNING & RELEASE OF LIABILITY BY STUDENT IF STUDENT IS 18 YEARS OLD OR OLDER

I, _____ (**student**), hereby acknowledge that I have been properly advised, cautioned and warned by the personnel of Achievement First Amistad High School of the risks involved with participation in the following sport(s): _____ (**choose from soccer, football, cross country, volleyball, field hockey, basketball, track, cheerleading, and/or lacrosse**). I acknowledge that even with the best coaching, use of appropriate equipment and strict observance of rules, injuries are still a possibility. I am exposing myself to the risk of serious injury, including but not limited to, the risk of sprains, fractures and ligament and/or cartilage damage which could result in a temporary or permanent, partial or complete, impairment in the use of his/her limbs; brain damage; paralysis; or even death. Having been so cautioned and warned, it is still my desire to participate in the above sport(s), and I hereby further acknowledge that I do so with full knowledge and understanding of the risk I am exposing himself/herself to by participating in such sport(s). I hereby hold Amistad Academy, Inc., Achievement First, Inc. and any of their affiliates, employees or agents harmless from and against any liability resulting from or occurring in connection with my participation in the above sport(s) listed above including but not limited to injury, death or sickness occurring in connection with or aggregated by his/her participation in the sport listed above and any consequences directly or indirectly resulting from such participation.

Student's signature | Date

Student-Athlete Off Season Team Activities

Amistad High School's athletic teams do have team activities during the off season. The dates for these activities will be determined by the head coach and will be sent home with students.
I hereby give my permission for (name of student)_____to attend off season conditioning practices.

Parent's/Guardian's signature | Date

MEDICAL PROVIDER INFORMATION

If the physicians of your choice cannot be reached, a different physician or other medical professional may called upon to administer medical treatment.

☐ Yes, please explain _____

☐ No

Family Physician | Phone

Family Dentist | Phone

EMERGENCY MEDICAL AUTHORIZATION

In the event that reasonable attempts to contact me (parent/guardian) or other individuals listed above have been unsuccessful, I hereby give my consent for the administration of any medically necessary emergency treatment.

Parent's/Guardian's signature | Date

PERMISSION TO BE TRANSPORTED AND CHARGED

I give permission for my son/daughter to be transported by private cars or buses provided by the school for athletic activities I have signed them up for. I agree to reimburse Achievement First Amistad High School for equipment issued to my child should it become lost. I understand that Achievement First Amistad High School cannot accept responsibility for personal items or school uniforms lost or stolen.

Furthermore, AF Amistad High School needs to make sure that your student-athlete is arriving at practices and games safely and getting home safely as well. The AFAHS athletic department is happy to provide the option of students traveling on a school provided bus to practices and games. Also, AFAHS provides busses which transports students from one of our athletic facilities to either the intersection of Church St. and George St. in New Haven, AF Amistad High School, and/or AF Bridgeport Academy after practices and games. There are other ways for student-athletes to get home such as:

1. Students may walk to practice.
2. Students may get a ride to practice.
3. Students may be picked up by their parent/guardian after practices and games.
4. Students may be picked up by adults who are approved by the student-athlete's parent/guardian after practices and games.
5. Students may walk or take a city bus home from practices/games if permission is given by the parent/guardian.
6. Students may take the AFAHS provided school bus to the intersection of Church and George in New Haven.
7. Take the AFAHS provided school bus to Achievement First Bridgeport Academy.

In the space below, please list any method of transportation you forbid your child from taking home after practice.

My child may not take the use the following methods to get home after Amstad athletic events:

_____

Parent's/Guardian's signature | Date

Student - Athlete & Parent Contract

Coaches' Code of Conduct

1. Ensure the safety and well-being of all students, parents, spectators and other coaches at all times.
2. Be positive, professional, well-prepared, and well-organized at all practices, contests, and events.
3. Teach character, sportsmanship, and teamwork first: success and winning are natural results of teaching these principles.
4. Support your students in all they do and be a positive and lasting presence in their lives.
5. Be a good manager of students, coaches, parents, and fans.
6. Be a good communicator with students, parents, administrators, the press, and the public.
7. Promote the whole Amistad High School Athletic Program to our students. Never promote one sport or team over another.
8. Make yourself available to students, administrators, faculty, and parents for meetings and school events.
9. Feel free to contact the director of athletics with questions, comments, or concerns; communicate any abnormal behavior or incidents – positive or negative.
10. Work hard to make Amistad High School the best.

Student-Athlete's Code of Conduct

1. Accept the responsibility and privilege the student-athlete has in representing your school
2. Attend all team meetings, practices, and competitions. Or, directly contact your head coach in advance of unavoidable absences.
3. Demonstrate respect for your opponents, their fans and the game officials
4. Keep sportsmanship and scholarship as top priorities.
5. Be a fierce and friendly competitor.
6. Cooperate with your coaches, teammates, opponents, and the officials.
7. Never argue with officials or complain about calls.
8. Work for the good of your team at all times during the season and out of the season.
9. Refrain from the use of illegal substances to gain an unfair advantage.
10. Abide by all the rules of the game.

Parent's Code of Conduct

1. Praise effort and commitment – much more than results.
2. Come to as many of the contests and competitions as possible.
3. Remember that young people play for their own enjoyment, not yours.
4. Help students manage their time and balance their schedules.
5. Never criticize a coach as it will confuse players. It not only divides loyalty, but offers an excuse.
6. If you would like to discuss something with a coach, set up a meeting to do so. Never complain to a coach after a game.
7. Never publicly criticize or question a referee's judgment or integrity.
8. Attend your child's team pre-season meeting.
9. Cheer loudly and positively for AHS.
10. Don't hesitate to contact the athletic director with questions, comments, or concerns.

Parent's/Guardian's signature | Date

Student-Athlete's signature | Date

Parent's/Guardian's signature | Date

AF Amistad High School
Student & Parent - Concussion Education Plan & Consent Form
2015-16

NOTE: This document was developed to provide coaches with an annual review of current and relevant information regarding concussions and head injuries. A new form is required to be read, signed, dated and kept on file by their associated school district annually to comply with Public Act No. 14—66 AN ACT CONCERNING STUDENT ATHLETES AND CONCUSSIONS.

A concussion is the immediate and transient alteration of neurological function in the brain caused by mechanical acceleration and deceleration forces.

***Part I – SIGNS AND SYMPTOMS* OF A CONCUSSION**

- A concussion should be suspected if any one or more of the following signs or symptoms are present, OR if the coach/evaluator is unsure.

1. Signs of a concussion may include (what the athlete looks like):

- Confusion/disorientation/irritability
- Trouble resting/getting comfortable
- Lack of concentration
- Slow response/drowsiness
- Incoherent/ slurred speech
- Slow/clumsy movements
- Loss of consciousness
- Amnesia/memory problems
- Act silly/combative/aggressive
- Repeatedly ask same questions
- Dazed appearance
- Restless/irritable
- Constant attempts to return to play
- Constant motion
- Disproportionate/inappropriate reactions
- Balance problems

2. Symptoms of a concussion may include (what the athlete reports):

- Headache or dizziness
- Nausea or vomiting
- Blurred or double vision
- Oversensitivity to sound/light/touch
- Ringing in ears
- Feeling foggy or groggy

Note: Public Act No. 14-66 requires that a coach MUST immediately remove a student- athlete from participating in any intramural or interscholastic athletic activity who (A) is observed to exhibit signs, symptoms or behaviors consistent with a concussion following a suspected blow to the head or body, or (B) is diagnosed with a concussion, regardless of when such concussion or head injury may have occurred**. Upon removal of the athlete a qualified school employee must notify the parent or legal guardian within 24 hours that the student athletes has exhibited the signs and symptoms of a concussion.**

Part II – RETURN TO PARTICIPATION (RTP)

Currently, it is impossible to accurately predict how long concussions will last. There must be full recovery before someone is allowed to return to participation. Connecticut Law now requires that no athlete may resume participation until they have received written medical clearance from a licensed health care professional (Physician, Physician Assistant, Advanced Practice Registered Nurse, Athletic Trainer) trained in the evaluation and management of concussions.

Concussion management requirements:

1. No athlete SHALL return to participation (RTP) on the same day of concussion.
2. Any loss of consciousness, vomiting or seizures the athlete MUST be immediately transported to the hospital.
3. Close observation of an athlete MUST continue following a concussion. This should be monitored for an appropriate amount of time following the injury to ensure that there is no escalation of symptoms.
4. Any athlete with signs or symptoms related to a concussion MUST be evaluated from a licensed health care professional (Physician, Physicians Assistant, Advanced Practice Registered Nurse, Athletic Trainer) trained in the evaluation and management of concussions.
5. The athlete MUST obtain an initial written clearance from one of the licensed health care professionals mentioned above directing them into a well defined RTP stepped protocol similar to one outlined below. If at any time signs or symptoms should return during the RTP progression the athlete should cease activity*.
6. After the RTP protocol has been successfully administered (no longer exhibits any signs or symptoms or behaviors consistent with concussions) , final written medical clearance is required by one of the licensed health care professionals mentioned above for them to fully return to unrestricted participation in practices and competitions.

Medical Clearance RTP protocol (Recommended one full day between steps)[2]

Rehabilitation stage	Functional exercise at each stage of rehabilitation	Objective of each stage
1. No activity	Complete physical and cognitive rest until asymptomatic. School may need to be modified.	Recovery
2. Light aerobic activity	Walking, swimming or stationary cycling keeping intensity ,<70% of maximal exertion; no resistance training	Increase Heart Rate
3. Sport Specific Exercise	Skating drills in ice hockey, running drills in soccer; no head impact activities	Add Movement
4. Non-contact Training drills	Progression to more complex training drills, ie. passing drills in football and ice hockey; may start progressive resistance training	Exercise, coordination and cognitive load
5. Full Contact Practice	Following final medical clearance, participate in normal training activities	Restore confidence and assess functional skills by coaching staff

* If at any time signs or symptoms should worsen during the RTP progression the athlete should stop activity that day. If the athlete's symptoms are gone the next day, s/he may resume the RTP progression at the last step completed in which no symptoms were present. If symptoms return and don't resolve, the athlete should be referred back to their medical provider

Part III - HEAD INJURIES

– Injuries to the head includes:

- Concussions: (See above information). There are several head injuries associated with concussions which can be severe in nature including:
  a) Second impact Syndrome - Athletes who sustain a concussion, and return to play prior to being recovered from the concussion, are also at risk for Second Impact Syndrome (SIS), a rare but life-altering condition that can result in rapid brain swelling, permanent brain damage or death; and
  b) Post Concussion Syndrome - A group of physical, cognitive, and emotional problems that can persist for weeks, months, or indefinitely after a concussion.
- Scalp Injury: Most head injuries only damage the scalp (a cut, scrape, bruise or swelling)… Big lumps (bruises) can occur with minor injuries because there is a large blood supply to the scalp. For the same reason, small cuts on the head may bleed a lot. Bruises on the forehead sometimes cause black eyes 1 to 3 days later because the blood spreads downward by gravity;
- Skull Fracture: Only 1% to 2% of children with head injuries will get a skull fracture. Usually there are no other symptoms except for a headache at the site where the head was hit. Most skull fractures occur without any injury to the brain and they heal easily;
- Brain Injuries are rare but are recognized by the presence of the following symptoms:
  (1)difficult to awaken, or keep awake or (2) confused thinking and talking, or (3) slurred speech, or (4) weakness of arms or legs or (5) unsteady walking"(American Academy of Pediatrics – Healthychildren, 2010) .

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I have read and understand this document the "Student/Parent - Concussion Education Plan & Consent Form" and understand the severities associated with concussions and the need for immediate treatment of such injuries.

Student name: _____ Date _____ Signature _____
(Print Name)

Parent name: _____ Date _____ Signature_____
(Print Name)

References:

1. NFHS. Concussions. 2008 NFHS Sports Medicine Handbook (Third Edition). 2008: 77-82. http://www.nfhs.org.
2. McCrory, Paul MBBS, PhD; Meeuwisse, Willem MD, PhD; Johnston, Karen MD, PhD; Dvorak, Jiri MD; Aubry, Mark MD; Molloy, Mick MB; Cantu, Robert MA, MD. Consensus Statement on Concussion in Sport 3rd International Conference on Concussion in Sport Held in Zurich, November 2008. Clinical Journal of Sport Medicine: May 2009 - Volume 19 - Issue 3 - pp 185-200 http://journals.lww.com/cjsportsmed/Fulltext/2009/05000/Consensus_Statement_on_Concussion_in_Sport_3rd.1.aspx.
3. Centers for Disease Control and Prevention. *Heads Up: Concussion in High School Sports*. http://www.cdc.gov/NCIPC/tbi/Coaches_Tool_Kit.htm.
4. U.S. Department of Health and Human Services Centers For Disease Control and Prevention. *A Fact Sheet for Coaches*.(2009). Retrieved on June 16, 2010. http://www.cdc.gov/concussion/pdf/coaches_Engl.pdf
5. American Academy of Pediatrics - Healthychildren. *Symptom check: Head Injury*. Retrieved on June 16, 2010. http://www.healthychildren.org/english/tips-tools/symptom-checker/pages/Head-Injury.aspx

Resources:

- Centers for Disease Control and Prevention. *Injury Prevention & Control: Traumatic Brain Injury*. Retrieved on June 16, 2010. http://www.cdc.gov/TraumaticBrainInjury/index.html
- Centers for Disease Control and Prevention. *Heads Up: Concussion in High School Sports Guide for Coaches*. Retrieved on June 16, 2010.

State of Connecticut Department of Education

Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant or the school medical advisor prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity	❑ Black, not of Hispanic origin
Primary Care Provider	❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other
Health Insurance Company/Number* or Medicaid/Number*		
Does your child have health insurance? Y N Does your child have dental insurance? Y N	If your child does not have health insurance, call **1-877-CT-HUSKY**	

* If applicable

Part I — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian Date

To be maintained in the student's Cumulative School Health Record

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

❑ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

***Height** _____ in. / _____% ***Weight** _____ lbs. / _____% **BMI** _____ / _____% **Pulse** _____ ***Blood Pressure** _____ / _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen					
Genitalia/ hernia					
Skin					

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

Screenings

***Vision Screening**

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Referral made

***Auditory Screening**

Type:	Right	Left
	❑ Pass ❑ Fail	❑ Pass ❑ Fail

❑ Referral made

	Date
Lead:	
***HCT/HGB:**	
Other:	

TB: High-risk group? ❑ No ❑ Yes PPD date read: Results: Treatment:

*IMMUNIZATIONS

❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of the **Asthma Action Plan** to School*

Anaphylaxis ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source

Allergies *If yes, please provide a copy of the **Emergency Allergy Plan** to School*
History of Anaphylaxis ❑ No ❑ Yes Epi Pen required ❑ No ❑ Yes

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:**

Seizures ❑ No ❑ Yes, type:

❑ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
Explain: _____

Daily Medications (*specify*): _____

This student may: ❑ **participate fully in the school program**
❑ participate in the school program with the following restriction/adaptation: _____

This student may: ❑ **participate fully in athletic activities and competitive sports**
❑ participate in athletic activities and competitive sports with the following restriction/adaptation: _____

❑ Yes ❑ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? ❑ Yes ❑ No ❑ I would like to discuss information in this report with the school nurse.

_____

Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap						
IPV/OPV	*	*	*			
MMR						
Measles	*	*				
Mumps	*					
Rubella	*					
HIB	*				Students under age 5	
Hep A						
Hep B	*	*	*			
Varicella	*					
PCV					Pneumococcal conjugate vaccine	
Meningococcal						
HPV						
Flu						
Other						

Disease Hx of above _____ (Specify) _____ (Date) _____ (Confirmed by)

Exemption

Religious _____ Medical: Permanent _____ Temporary _____ Date _____

Recertify Date _____ Recertify Date _____ Recertify Date _____

Immunization Requirements for Newly Enrolled Students at Connecticut Schools

KINDERGARTEN
DTaP: At least 4 doses. The last dose must be given on or after 4th birthday
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hib: Children less than 5 yrs of age need 1 dose at 12 months or older Children 5 and older do not need proof of Hib vaccination
Hep B: 3 doses
Varicella: 1 dose on or after the 1st birthday or verification of disease

GRADES 1-6
DTaP /Td/Tdap: At least 4 doses. The last dose must be given on or after 4th birthday
Students who start the series at age 7 or older only need a total of 3 doses
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hep B: 3 doses
Varicella: 1 dose on or after the 1st birthday or verification of disease

GRADES 7-12
Td/Tdap: At least 3 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hep B: 3 doses
Varicella: 1 dose on or after first birthday or verification of disease:
VARICELLA VACCINE: For students <13 years of age, 1 dose given on or after the 1st birthday. For students 13 years of age or older, 2 doses given at least 4 weeks apart
VERIFICATION OF DISEASE: Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history

Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number